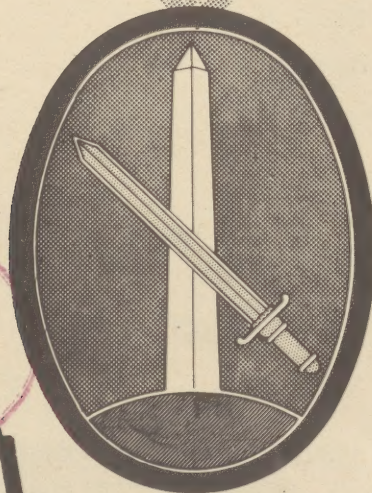


VOLUME 3
REPORT NO. 10

(DOCUMENT SECTION)
RESTRICTED

MONTHLY HEALTH REPORT

Military District of Washington



ARMY
MEDICAL
NOV 20 1950

LIBRARY

RESTRICTED

October 1950



THIS DOCUMENT CONTAINS INFORMATION
AFFECTING THE NATIONAL DEFENSE OF
THE UNITED STATES WITHIN THE MEANING
OF THE ESPIONAGE LAWS, TITLE 18, U.S.C.,
SECTIONS 793 AND 794. THE TRANSMISSION
OR THE REVELATION OF ITS CONTENTS IN
ANY MANNER TO AN UNAUTHORIZED PER-
SON IS PROHIBITED BY LAW.

HEADQUARTERS, MILITARY DISTRICT OF WASHINGTON
Room 1543, Building T-7, Gravelly Point
Washington 25, D. C.



INTRODUCTION

This publication presents periodic health data concerning personnel of the Department of the Army in the Military District of Washington. It provides factual information for measurement of increase or decrease in the frequency of disease and injury occurring at each of the posts, camps or stations shown herein.

It is published monthly by the Military District of Washington for the purpose of conveying to personnel in the field current information on the health of the various military installations in this area and on matters of administrative and technical interest. Items published herein do not modify or rescind official directives, nor will they be used as a basis for requisitioning supplies or equipment.

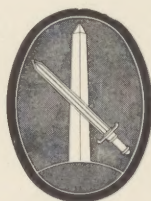
Contributions, as well as suggested topics for discussion, are solicited from Army Medical Service personnel in the field.

A handwritten signature in cursive script, reading "Robert E. Bitner".

ROBERT E. BITNER
Colonel, MC
Surgeon

CONTENTS

ADMINISTRATIVE SERVICE		PAGE
Appointment of Individuals in Army Nurse Corps, Regular Army		9
Command and Staff Relations of Surgeon With Commander		6
Morale		9
Penalty Mail Matter		7
Physical Standards		8
Table -- Outpatient Service		22
Table -- Hospital Mess Administration		22
CIVILIAN EMPLOYEES' HEALTH SERVICE PROGRAM		
Civilian Employee Health Service Report		24
Department of Defense Blood Donor Program		23
DENTAL SERVICE		
Dental Service in the Army		10
Table -- Dental Service		22
MEDICAL BATTALION		
Ambulance Company of the Medical Battalion		4
PREVENTIVE MEDICINE		
Sick Call		1
Intern Training at U.S. Army Hospital, Fort Belvoir, Va.		2
Residency Training		3
A Method of Obtaining Running Water for Surgical Scrubbing in the Field		11
The Common Cold and Its Implications		13
Sulfanilamide		14
General Comment		15
Communicable Disease		15
Table -- General Data		16
Table -- Admissions, Specified Disease		16
Venereal Disease		17
Table -- New Venereal Disease Cases		17
Chart -- Admission Rates of Common Respiratory Disease and Injury		18
Chart -- Venereal Disease Admission Rates by Month		18
Table -- Consolidated Venereal Disease Statistical Report		21
Table -- Venereal Disease Rates for U. S.		20
Chart -- Venereal Disease Total Rates		20
Chart -- Venereal Disease White Rates		19
Chart -- Venereal Disease Negro Rates		19
VETERINARY SERVICE		
Table -- Veterinary Service		22



PREVENTIVE MEDICINE

SICK CALL

By

Colonel Robert E. Bitner, MC

Sick Call is an Army formation of long standing. Commanding Officers of units establish certain time for non-emergency cases to report to the medical units for medical attention. While Sick Call is usually held in the morning, there is no regulation which prohibits its being held at any other time. Some stations may find it more convenient to schedule Sick Call in the afternoon, at others evening hours may be utilized. At some installations due to the type of training or employment of troops it may be necessary to schedule two (2) Sick Calls in any one day. Occasionally the unit dispensary may have to establish a particular time for certain organizations because of the number of individuals appearing on Sick Call and other local controlling factors. The mission of the individual unit regulates the time of Sick Call.

Army Regulation 40-505 states "ordinarily Sick Call is not a suitable time for the careful examination and definitive treatment of the sick and wounded". This is not to be interpreted as meaning that Sick Call is not the time to do all that is possible for the patient, but rather the medical officer must make a hasty screening of the individuals appearing on Sick Call. This hasty screening is necessary to determine which patients have minor conditions and which patients have conditions requiring more detail attention. Minor conditions may require the redressing of a wound, soaks, light treatment, or the refilling of a prescription, etc. Such conditions can, after a less detailed examination than is needed for more complicated conditions, be cared for by the Army nurse or enlisted personnel assigned to the dispensary for Sick Call duty. Grouping cases enumerated above will speed up the Sick Call. This practice of grouping cases cannot be too strongly emphasized. After the hasty survey and screening by the medical officer, the cases requiring a more detail examination can be assigned to routine examination, such as, a urinalysis, a blood count when indicated, a temperature reading, a blood pressure reading, etc. These procedures can be accomplished while the doctor is caring for other patients.

Why is this manner of efficiency required? The answer can be simply stated - to conserve time. Who's time? The time of the soldier, and the time of the Medical Service personnel. Why is this so necessary? Simply to afford the maximal utilizable time of the Government. Training requirements are heavy. In this day of modern warfare with the complicated machines necessary it becomes incumbent upon everyone to spend as much time as possible learning about these machines and his individual part in their operation. To protect himself against similar weapons of the enemy the soldier must learn all of the tricks of the trade and become hardened to the rigors of the game. Every minute of the time spent by the individual in the dispensary on Sick Call results in the loss of that individual's services to his unit. This affects training. In an indirect way training is affected when a soldier assigned to some housekeeping duty is kept too long on Sick Call. This would necessitate the assignment of another soldier to his details to govern the period of his absence. This other soldier may be undergoing some important phase of training. Time spent on Sick Call for trivial matters is wasted.

The Medical Officer must develop in himself the ability to pick out of the group the ill person, and do this quickly. This person will need a more detailed examination, after obtaining a good history. This is the individual that the medical officer can spend more time on. He should do this only after the minor cases have been channeled to his assistants. It is wasteful of everyone's time to have a number of soldiers waiting to have a dressing applied, to have a light treatment, or a foot soak while the medical officer is taking care of a patient. At the same time the enlisted men of the Medical Service and the nurse may be standing around waiting for something to do. Learn to group cases; learn to give your attention to the really sick. You have, or should have if you have carried out your end of the training, competent enlisted personnel who can carry out minor procedures.

The medical officer must become a psychiatrist to some degree. Almost every man that comes on Sick Call has a problem. Not every man will need medicine. Doctor William Menninger has said: "In some degree, the necessity to know and utilize psychiatric principles confronts every medical officer in the Army. Some of the best preventive psychiatry is being carried out by general medical officers in the dispensary; in the consultation services; in the out-patient clinics, on the landing field and in the division clearing stations". His full article "Relationships of Neuropsychiatry to General Medicine and Surgery in the Army" which appeared in the February 1945 issue of "The Mil-

PREVENTIVE MEDICINE

tary Surgeon" is recommended for reading. In some cases the medical officer cannot solve the soldier's problem. The problem may be one that should come to the attention of the soldier's Commanding Officer, however, an understanding Commanding Officer may be able to do much for such a soldier. The Medical Officer should have a speaking relationship with these officer for this very reason.

Cases that require hospitalization should be so handled that they arrive at the hospital in the morning or early afternoon. This pertains to the non-emergency case, of course. Such early arrival is playing only fair to the hospital. There is one other point that I desire to mention in regard to cases being sent to the hospital, and that is: let the hospital know by some means if the patient needs to be handled by other than routine procedures. This is being fair, not only to the hospital, but also to the patient.

In summary then: (1) Screen cases (2) Use assistant's to carry out the procedures that they are able to do (3) Conserve your time, the Commanding Officers time and the soldier's time (4) Be a psychiatrist.

INTERN TRAINING AT THE US ARMY HOSPITAL, FORT BELVOIR, VIRGINIA By M. F. DuFrenne, Colonel, MC Commanding

Every doctor should be a student and every hospital should be a teaching hospital. This should be true whether there is any formal training to be done or not. However, a formal teaching program benefits every hospital by: Stimulating reading of current literature; requiring the preparation of formal conference material; stimulating discussions; and by generally keeping everyone alert and abreast of new developments.

At the present time three interns are assigned to the surgical service of the Army Hospital, Fort Belvoir, Virginia for two months period on rotation from Walter Reed Army Hospital. One is assigned to general surgery, one to gynecology and women's surgery and one to obstetrics. The latter two change with one another after one month. The intern is responsible for seeing each patient initially, and performing a history and physical examination. He is responsible for writing all orders on each patient under supervision of the permanent staff members. It is thought that this is a necessary part of the intern's training so that he may be acquainted with the treatment and diagnostic procedures of each case. If a patient is operated on, the intern is assigned as a part of the operating team and writes the post-operative orders. In this way he gets to see first hand the entire treatment of each case. Interns make daily ward rounds with a member of the assigned staff at which time decisions are made regarding diagnostic procedures to be accomplished, surgery to be done, drugs to be administered, etc. The intern assigned to obstetrics is allowed, after an initial period of orientation and assisting in deliveries, to perform all normal deliveries under direct supervision of a staff member. Usually each intern assigned to obstetrics for one month personally delivers approximately fifty to sixty infants.

In addition to the work on the wards, operating room and delivery room, a series of conferences have been set up for the benefit of both the interns and permanent staff members. On Monday afternoon a surgical conference is conducted by a member of the permanent staff on a subject which is of general surgical interest and which is illustrated by cases on the wards. The interns take part in the discussion and frequently are asked to give their views on various parts of the discussion. Recent subjects included the differential diagnosis of appendicitis, gastro-intestinal bleeding, and post-operative care.

On Wednesday afternoon an X-ray conference is conducted by the Chief of X-ray Service. This conference is divided into two parts. First, normal and pathological films are shown from the teaching file. These are organized into subjects such as chest, abdomen, fractures, etc. Secondly, interesting cases from the past week are shown and discussed.

PREVENTIVE MEDICINE

On Thursday afternoon an orthopedic clinic is held by the Surgical Consultant, Office the Surgeon General of the Air Force, who kindly devotes one afternoon each week for this purpose. At this time, problem cases are presented by interns and permanent staff officers for consideration by the Consultant who makes recommendations and presents discussions on various cases. Arrangements are made for the Consultant to operate on selected cases.

On Friday afternoon a conference on obstetrics and gynecology is given by a Diplomat of the American Board of Obstetrics and Gynecology. In these sessions common obstetrical and gynecological problems are discussed. These have included treatment of threatened abortion, indications for Caesarian sections, sterility, etc. Following the presentation a general discussion including a question and answer period is held.

On Saturday morning the interns make ward rounds on all surgical wards conducted by the permanent staff members. Interesting and problem cases are discussed at this time. In addition to in-patient care interns also work in the out-patient clinic. The intern on general surgery assists in conducting the minor surgery clinic and performs, under supervision, minor surgery which can be done on out-patients. This clinic is conducted on Tuesday afternoon. Permanent staff members conduct the surgical out-patient clinic on Tuesday and Friday afternoons. The interns on obstetrics and gynecology see out-patients daily in the women's clinic.

An intern roster designates coverage of all surgical wards at all times and requires each intern to be on call two nights out of three. In this way an intern sees each patient initially, examines him and makes up his own mind about the case before calling a staff member. If an operation is performed he scrubs on the case. It is thought that in this way the individual learns more. In addition, each intern after a period of observation and assistance, is allowed to do as much in the way of surgery as he is though capable of handling. Each surgical intern before he finishes his tour usually performs at least one appendectomy, assisted by members of the permanent staff.

An essential facility in any teaching program is an adequate medical library. Since the present program was started the medical library at this hospital has been enlarged and moved to more suitable quarters. Books and journals are arranged in an accessible manner on tables and shelves. Interns are encouraged to do collateral reading during their evenings on call when time is available.

It is thought that the program, as it is set up, is of benefit to the patients, interns, and assigned staff, and helps to elevate the professional standards of the hospital:

ACKNOWLEDGEMENT

It gives me great pleasure to acknowledge the fine supervision and direction of this training program by Robert M. Hardaway, III, Lt Colonel, MC, Chief of Surgical Service and the cooperation of the staff of the Surgical Service, Radiology and the Surgical Consultant of the Air Force, Oscar S. Reeder, Colonel, MC.

* * *

RESIDENCY TRAINING

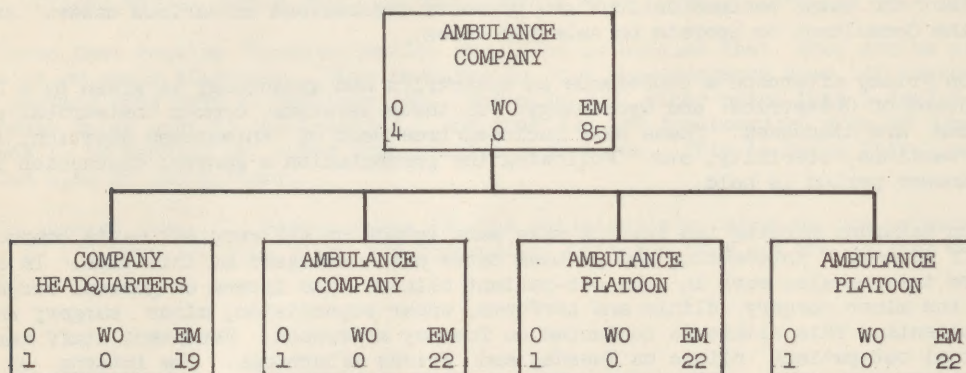
All medical officers who were engaged in residency training, either civilian or military, and withdrawn from that training because of the national emergency, should keep a record of the duties in which they are engaged.

It is believed that certain specialty boards will give credit (practice credit) for military service duties.

A booklet is now being prepared by the Council on Medical Education and Hospitals of the American Medical Association.

MEDICAL BATTALION

AMBULANCE COMPANY OF THE MEDICAL BATTALION



a. General. The function of the ambulance company is primarily that of transport, that is, the evacuation of sick and wounded from the regimental collecting stations and, when required, from battalion aid stations of separate battalions, back to the division clearing stations. The ambulance company is capable of evacuating from the three regimental collecting stations to the three clearing stations that the clearing company of the medical battalion may operate. This situation probably would develop if three combat teams were committed into action at the same time. It may be called upon to furnish transportation for personnel of the clearing company during movement of the battalion.

b. Company Headquarters.

(1) The commanding officer, a captain, MSC, is responsible for the administration, discipline, training, and operation of the company. He maintains liaison with the clearing company, battalion headquarters, and regimental medical companies. The company commander maintains liaison with the regimental medical companies by means of the ambulance platoon leaders. Each platoon has a technical sergeant, who is the platoon sergeant. Each platoon also has a staff sergeant as a section leader, and he may act as a liaison agent. A 1/4-ton truck is driven by the staff sergeant in his duties as liaison agent. The company commander is assisted in administration by a first sergeant and a company clerk. The platoon leader of the first platoon is the company executive officer. The company headquarters is usually set up in the vicinity of the clearing station and battalion headquarters.

(2) The mess section under the mess steward is charged with the preparation of meals for the personnel of the company. The mess section has four cooks and a mess attendant in addition to the mess sergeant.

(3) The motor section under the motor sergeant, provides organizational motor maintenance for motor vehicles assigned to the company. The motor sergeant is assisted in the motor maintenance by three mechanics. Organizational maintenance is performed by the vehicle driver and his assistant and by the mechanics of the using organization. The responsibility for this maintenance rests with the commanding officer of the organization which operates the vehicles.

(4) The supply section under the supply sergeant is charged with the requisition, storage, and issue of all supplies used by the company. Company headquarters submits requisitions for both general and medical supplies to the battalion supply officer (S-4), who consolidates the requisitions from all units of the medical battalion and submits the consolidated requisitions to higher authority. Medical supplies for this unit will be limited to replacement, since the unit will normally be engaged in the transport of the sick and wounded. However, the unit may be called upon

MEDICAL BATTALION

to transport medical supplies from the division medical supply point to the regimental collecting stations. Medical property, such as litters, blankets, and splints, accompanying patients to the rear, must be replaced by automatic exchange with the rearward medical unit which receives the patient. This is called property exchange. The ambulance driver will leave a litter and a blanket at the regimental collecting station when a patient, with a litter and a blanket, is placed in the ambulance. When the patient is delivered to the clearing station, the ambulance driver will receive a litter and blanket in exchange for the ones the patient is using.

c. Ambulance Platoon. There are three identical ambulance platoons in the company.

(1) Platoon Headquarters. Each platoon is commanded by an officer, MSC, assisted by a platoon sergeant. The platoon leader supervises functioning of the platoon ambulances including loading, operation along the route, and unloading. The platoon leader has under his control, a platoon sergeant, a section sergeant, ten ambulance drivers, and ten orderlies. The platoon leader, in performing his duties, must operate between the collecting station and the clearing station. To perform this duty, he is provided with a 1/4-ton truck and driver (the section sergeant). The specific duties of the platoon leader are:

- (a) Supervision of loading and unloading of ambulances.
- (b) Checking patients against list provided by the collecting station.
- (c) Insure that property exchange takes place.
- (d) Regulating speed, spacing, and routing of ambulances.
- (e) Acting as liaison officer between regimental medical companies and company or battalion headquarters.

(2) Each platoon generally operates ten ambulances. Each is staffed with a driver and an orderly. The driver, assisted by the orderly, is charged with: operation and organizational maintenance of the ambulance; assisting in loading and unloading of the ambulance; property exchange on loading and unloading the ambulance; and care of patients while en route. Each ambulance will, in addition to the equipment habitually carried for the mechanical upkeep of the vehicle, be equipped with such special equipment as is directed by higher authority for the care and treatment of patients en route and for property exchange. Some additional duties the ambulances may be called upon to perform are: in bivouac, to transport sick and injured from unit dispensaries to clearing station; to transport medical supplies and medical personnel.

d. Operation.

(1) Normally, the company is committed as follows: Each ambulance platoon is charged with the responsibility of evacuating one of the regimental medical companies (In defensive actions it may be possible to use only a section from each platoon and to commit the remainder to reserve or to other units of the division.)

(a) In the evacuation of the regimental medical companies the ambulance shuttle system may be employed in order to permit dispersion of vehicles and to aid in assuring a steady flow of casualties from the collecting station to the clearing station. One empty ambulance is camouflaged and stationed at the forwarding department of the collecting station. This is called the ambulance loading post (ALP). Two ambulances are placed 200 to 300 yards from the collecting station at a site just off the road which offers defilade and concealment. This pair of ambulances, well separated so as to lessen the effect of enemy fire, is called an ambulance relay post (ARP). The remainder of the supporting ambulances are dispersed in a defilade position at a distance of 600 to 3,500 yards behind the collecting station. This position is the basic relay post (BRP), and acts as a reservoir of ambulances where vehicles are serviced and personnel are rested. Two or more ARP's may be established if the distance to the clearing station is great.

MEDICAL BATTALION

(b) When an ambulance fully loaded with casualties from the collecting station passes the ARP, one of the ambulances located at the ARP then moves to the first position, the ALP. As the loaded ambulance passes the BRP, an ambulance from the BRP moves up to the ARP. After the rearward bound ambulance discharges its patients at the clearing station it reenters the shuttle at the BRP.

(c) Since the distance from the front lines of the collecting station will ordinarily vary from 1,200 to 3,500 yards (approximately one mile), and the distance from the front lines to the clearing station is from four to ten miles, a one way trip will vary from three to nine miles. The distance the patient travels depends upon the roads and the tactical situation.

e. Training. The three ambulance platoons are trained in individual and convoy driving, on roads and cross-country, by day and night, and with and without lights; in the emergency repair of roads and bridges; in the extrication of ambulances from obstacles; in the loading of ambulances; in camouflage, concealment, and the use of terrain for protection, both moving and at rest; in emergency medical treatment; in organizational motor maintenance; and in the operation of ambulance shuttles. Ambulance drivers and orderlies must be particularly skilled in the use of maps.

ADMINISTRATIVE SERVICE

COMMAND AND STAFF RELATIONS OF SURGEON WITH COMMANDER

1. As an officer of the Army Medical Service you may be subjected to assignment for duty as a company or detachment commander of a medical unit. It is imperative, therefore, that you have a general knowledge of the organizational and functions of the different medical units to which you may be assigned.

2. An officer of the Medical Corps is provided on the staff of every unit of which medical troops are a part; of every unit of combined Arms and Services and of every Territorial Command. Commanders are responsible for the medical service of their commands, whether the command be large or small and whether the exercise of the functions of commands be complex or simple, the commander must be the controlling head. Decisions as to the specific course of action in any given case is the responsibility of the commander alone. It is the task of the staff to furnish the commander with such information data and advice as he may require in reaching a decision. The authority to prescribe tasks for medical service involves a responsibility to provide adequate means for the accomplishment of these missions.

3. The commander is responsible for his medical service. The Surgeon is the Special Staff Officer charged with keeping the commander informed as to the conditions and capabilities of the medical service and elaborating the details necessary to carry the decision of the commander, as it concerns medical matters and the sick. As in the case of any staff officers, the commander may utilize the services of the Surgeon in a purely advisory capacity or he may detail to the Surgeon authority to act in the commanders name within established policies in affairs that fall properly within the jurisdiction of the medical service. The general responsibilities of the Surgeon to his commander are as follows:

a. To inform and advise the commander upon all matters that effect the health of the command and the care of the sick and injured, (necessity for medical reports and records from subordinate units, is apparent for the accomplishment of this responsibility). The commander is charged with having before him a conception of the physical state of his command at all times.

b. To submit to the commander plans for the training and employment of medical units. Responsibility for the medical service include the responsibility for its training. To act effectively, a command must operate as a coordinated whole. The medical plan is a part of the administrative plan of a command and must be fitted with the other subordinated plans. For this reason

ADMINISTRATIVE SERVICE

medical plans must be submitted for the approval of the commander. Because of the technical phases of training that are pertinent to the Army Medical Service Training, the Surgeon on his own initiative must inform the commander of the necessity and importance of devoting some time of the medical training to purely medical subjects. The Surgeon must exercise supervision for the commander over the technical aspects of the training and operation of the medical services of subordinate elements. This is purely a staff function and does not encroach upon the prerogatives of subordinate commanders.

4. It is the duty of the Surgeon to follow-up the execution of the instructions issued by the commander which apply to any phase of medical service.

5. When in addition to his staff duties a Surgeon commands a medical unit, his responsibilities to his commander are the same as those of any subordinate commander.

* * *

PENALTY MAIL MATTER

Reproduced below is paragraph 1b(1) of SR 340-10-1 for information and guidance:

"b. Use of penalty matter.

- (1) Envelopes, labels, wrappers, cards, tags, and other articles bearing the penalty clause will not be used for such purposes as --
 - (a) Personal communication.
 - (b) Conveyance of communications or material through other postal channels, such as message centers, security courier service, hand-carried interoffice communications, etc. (Envelopes or other containers not bearing the penalty indicia will be used for such purposes.)
 - (c) Placing penalty labels or tags on matter which already bears the penalty indicia.
 - (d) Transmitting mail matter when carrying postage, such as air mail or parcel post stamps, has been placed thereon. (Nonpenalty matter will be used for such purposes.)"

* * *

During the past two months two new improved forms have been distributed for Army-wide use. "Officer Efficiency Report" DA AGO Form 67-2 replaced DA AGO Form 67-1 effective 15 September 1950. This form should simplify the rater's task and still cover all of the salient items.

* * *

Standard Form 88 "Report of Medical Examination" and Standard Form 89 "Report of Medical History" are also now being used. These forms have been arranged so as to facilitate the task of typing and reviewing of the completed physical examination.

* * *

"Index of Administrative Publications" SR 310-20-5 dated 1 July 1950 lists Army Regulations (AR) and Special Regulations (SR) in paragraph 1 of the publication. The process of filing AR's and SR's together in one binder well alleviates the need of referring to two books in order to have the complete subject matter.

ADMINISTRATIVE SERVICE

PHYSICAL STANDARDS

Applicants for enlistment must meet fully the physical standards for acceptance as prescribed in AR 40-115. The standards for acceptance are as follows:

a. Regular Army - Applicants having a physical profile serial with the numerical "2" (profiles A and B) as the lowest grade in any factor may be accepted for enlistment in the Regular Army, except that for female applicants the numeral "2" (profile B) may apply for hearing and vision, but all other physical qualifications must carry a numeral "1" (profile A). (For applicants last discharged by reason of CDD, see d below.).

b. Air Force.

(1) Applicants having a physical profile serial with the numeral "2" (profiles A and B) as the lowest grade in any factor may be accepted for enlistment in the Air Force, except as provided below. In the case of female applicants for enlistment in the Air Force, the numeral "2" (profile B) may apply for hearing and vision, but all other physical qualifications must carry a numeral "1" (profile A). During such time as the individual's enlistment is not affected by any provisions of a Selective Service act, the following additional standards must be met:

(a) The minimum and maximum weight standards shown in paragraph 18, AR 40-105, standards of height, weight and chest measurements, will be applicable in lieu of the provisions of AR 40-115.

(b) In lieu of the applicable provisions of AR 40-115 concerning venereal disease, the following will apply:

1. Those male applicants with a history of syphilis are acceptable, provided the disease has been adequately treated and the individual presents no signs, symptoms, or abnormal serological findings on examination. In the case of female applicants, a history of venereal disease is immediately disqualifying.

2. Both male and female applicants having syphilis with confirmed positive serological tests or confirmed abnormalities of any test of the spinal fluid are nonacceptable.

(2) Air Force personnel being separated who contemplate reenlistment in the Air Force will be furnished a copy of their Standard Form 88 (Report of Medical Examination) accomplished at the time of separation. This standard form may be accepted for reenlistment purposes in the Air Force in lieu of medical examination, provided enlistment is accomplished within 30 days after date of discharge and applicant signs a certificate to the effect that he has had no injury or illness since discharge. This certificate will be prepared in duplicate and a copy will be attached to the original and duplicate copy of the enlistment record. The examining medical officer may require physical examination if deemed advisable. Airmen found physically qualified on separation, with or without waiver for physical defect, under the provisions of this paragraph, will be reenlisted irrespective of any objective physical defect, unless such condition is due to intervening injury or illness incurred since the time of separation. Waivers by Headquarters, United States Air Force, will not be required in these cases.

c. Request for Waiver. - Applicants who have had prior service in any of the armed forces and who do not meet the physical standards prescribed in a above, but who do meet the minimum standards for acceptance prescribed in AR 40-115, may be accepted for enlistment in the Regular Army, provided waiver is granted by The Adjutant General. In especially deserving cases of Air Force applicants in this category, normally those with six or more years' service, when the individuals do not meet the physical standards of b above, they may be enlisted, provided waivers are granted by the Chief of Staff, United States Air Force. Requests for waivers of physical defects will be accompanied by a complete report of physical examination and physical profile, recorded on Standard Form 88 (Report of Medical Examination) and Standard Form 89 (Report of Medical History), including detailed description and evaluation of the physical defect.

ADMINISTRATIVE SERVICE

d. Individuals Discharged by Reason of Physical Disability. - Applicants for enlistment in either the Army or the Air Force who were last separated by reason of physical disability will not be accepted for enlistment without prior approval from The Adjutant General for Army applicants and from the Chief of Staff, United States Air Force, for Air Force applicants, even though they currently meet the physical standards prescribed in a and b above. (See section VIII for reenlistment of personnel removed from the Temporary Disability Retired List.) (Discharge by reason of physical disability from the Navy, Marine Corps, and Coast Guard is governed by the following regulations: Navy-C-10305, BuPers Manual; Marine Corps - par. 10268, MCM 1949; Coast Guard-Art. 588, C.G. Regs.) Request for waiver of prior discharge by reason of physical disability will be accompanied by a complete report of physical examination and physical profile on Standard Forms 88 and 89, including a detailed description and current evaluation of the physical defect responsible for the individual's discharge. Requests for waivers will be forwarded as follows:

(1) Regular Army

(a) Applicants whose last prior active service was in the status of an enlisted person in the Army or Air Force to the Chief, Demobilized Personnel Records Branch, Records Administration Center, St. Louis 20, Missouri.

(b) Applicants other than those prescribed in (a) above to The Adjutant General, Washington 25, D. C., Attention: AGSE.

(2) Air Force. - Headquarters United States Air Force, Director of Training, ATTENTION: Airmen Procurement Branch, Personnel Procurement Division, Washington 25, D. C.

e. Individuals Reenlisting from Within Service. - Individuals reenlisting from within the service will be given a final type physical examination and physical profile under AR 40-115, within a period of 72 hours immediately prior to discharge for the purpose of immediate reenlistment and only those persons found acceptable as prescribed in a and b above will be reenlisted, except that, in an especially deserving case where the individual does not meet the prescribed standards and where the defect has not interfered with the performance of military duty, application may be forwarded to The Adjutant General, United States Army, or Chief of Staff, United States Air Force, prescribed in d(1) (b) and d(2) above, for consideration of waiver of physical defect. Application for waiver will be accompanied by the Report of Medical Examination and Report of Medical History (Standard Forms 88 and 89).

(The above article is from SR 615-105-1, 6 Sep 50)

* * *

APPOINTMENT OF INDIVIDUALS IN THE ARMY NURSE CORPS, REGULAR ARMY

Attention of members of the Army Nurse Corps who entered on active Federal service prior to 16 April 1947 and who have served honorably in the Army of the United States as commissioned officers in the capacity of nurses, or as members of the Army Nurse Corps, including status of reserve nurse is again directed to Circular No. 32, Department of the Army, dated 5 June 1950.

* * *

MORALE

Morale is a state of mind. It is steadfastness and courage and hope. It is confidence and zeal and loyalty. It is elan, esprit de corps and determination. It is staying power, the spirit which endures to the end-the will to win.

General George C. Marshall

DENTAL SERVICE

DENTAL SERVICE IN THE ARMY

a. Responsibility for groups, rather than for individuals, is the chief difference between the viewpoint of the Army dental officer and the civilian dental surgeon. Whereas, the civilian practitioner is generally concerned only with the welfare of those individuals who voluntarily present themselves for dental treatment, the Army dental surgeon is responsible for the dental health of a given command, and that responsibility to the group is threefold since it includes the prevention, the detection, and the treatment of dental diseases to the end that the dental health of each member of the group is maintained at the maximum level possible. The accomplishment of this objective requires a systematic approach and cannot be attained by furnishing dental care only to those who voluntarily come to the dental clinic for treatment.

b. Army Regulations require an annual dental survey of all enlisted men at stations or in commands which are regularly attended by a dental officer and specify that this survey will be made between 1 January and 30 June. It is further specified that special dental surveys will be made when indicated by local conditions. These surveys are a means of determining the dental status of each individual so that a comprehensive program of dental treatment may be developed which is based upon the overall needs of the command rather than the needs of certain individuals. Simple compliance with Army regulations in conducting surveys at specified times is not adequate since the dental status of members of a command is constantly changing as a result of dental services rendered from day to day. Thus, it is essential that changes in the dental status of individuals be recorded in a manner that surveys reflect such changes. Furthermore, the personnel of a command undergoes constant change as the result of transfers into or out of the unit. These are matters of local administration and the dental surgeon should attempt to establish with his unit headquarters some method of procedure whereby he is notified when personnel changes occur so that such changes may be kept current on his survey rosters.

c. The dental surgeon of a newly activated unit, or one who joins an organization wherein there is no record of an up-to-date dental survey, should take immediate steps to arrange for the accomplishment of same so that he may institute a dental program in accordance with the known needs of the command.

d. The detection by group surveys, and systematic follow-up treatment of diseases, abnormalities and deficiencies found, is a preventive program since it results in the arrest of conditions which already exist. However, it is also the responsibility of the dental surgeon to develop an educational program aimed at improving the oral hygienic habits of the members of the command. This program should include lectures, motion pictures, and demonstrations to groups, as well as individual instruction to patients, when undergoing treatment.

e. Professional procedures in the Army are identical with professional procedures in civilian practice, but the type of procedure to be adopted will often be influenced by the dental officer's responsibility to the group. The civilian dental surgeon may elect to utilize only gold for restorations in posterior teeth, but this would not be a satisfactory procedure in the Army because of the time factor involved and the large number of restorations required to keep abreast of the requirements of the average command. Consequently, well-placed alloy fillings in posterior teeth is the routine procedure in the Army. Again there is the problem of single tooth replacements, particularly of posterior teeth. Although a dental officer may believe that all missing teeth should be replaced he must realize that such a procedure would necessitate the curtailment of nearly all other operative procedures and would be detrimental to the dental health of the command as a whole. The Army dental surgeon is free to select such operative procedures as he considers advisable, but if he selects such time consuming procedures for a few that neglect of the majority results, he is not fulfilling his mission in regard to maintaining the dental health of the command at the highest possible level.

f. Military situations differ and the dental service rendered will vary in accordance with the situation. Because of this, there is a variation in the equipment which is authorized for different situations. The equipment of the dental service of a general hospital is far more elaborate than that authorized for a battalion in the field. In the general hospital there are facilities for the accomplishment of all manner of dental procedures while the battalion field equipment is limited to that minimum which is essential for routine procedures, such as filling operations, simple extractions, gum treatments, and emergency care. The equipment in the dental clinics of camps, posts, and

DENTAL SERVICE

stations is nearly as complete as the general hospital clinic, lacking only certain specialized equipment that is essential to the general hospital only.

g. In time of war, dental facilities and personnel are concentrated in the training camps and training areas for the purpose of accomplishing the maximum in dental care prior to the completion of training and the movement of units to the theater of operations. Although the objective in the zone of the interior is the completion of all required dental treatment for all personnel prior to departure for a theater of operation, the accomplishment of this objective is dependent upon the length of the training period, the number of personnel involved, and the dental personnel available. The minimum standard acceptable is the elimination of all nonrestorable teeth, the correction of all major carious defects, the treatment and elimination of oral infections and the furnishing of prosthetic dental appliances for those who have insufficient teeth to masticate the Army ration. It is essential then that dental surveys be based upon dental classification as established in Army Regulations 40-510, so that early concentrated effort may be directed toward all Class I cases and a program of treatment established whereby such cases will be eliminated by the end of the training period. With such a program established the next objective is to systematically remove from Class II as many persons as possible during the same period. The ideal objective is the elimination of all Class I and Class II cases, but time and personnel are governing factors and the elimination of all of the latter may not be possible.

h. Dental clinics of camps and training areas are established in accordance with the number of personnel normally present for duty and training. Such clinics are partially staffed with dental personnel permanently assigned to the camp or installation. Dental personnel assigned to units undergoing training are placed on duty in these dental clinics in accordance with existing Department of the Army directives. Such personnel remain under the command of the unit to which assigned but are required to observe the rules and regulations of the camp clinic during hours of duty therein. Such assignments must be coordinated with the unit headquarters to which these officers are assigned. Since the dental officers assigned to units undergoing training must undergo certain training as officers of their units, directives governing their utilization in the permanent or semi-permanent clinics will normally place a limit upon the amount of the training period during which they may be so employed. The administration of these dental clinics, the policies under which they operate and the accomplishment of the dental mission of the camp or installation is the responsibility of the dental surgeon, subject to the approval or disapproval of the camp or installation commander.

PREVENTIVE MEDICINE

A METHOD OF OBTAINING RUNNING WATER FOR SURGICAL SCRUBBING IN THE FIELD BY: Hyman Sneiersen, M.D., F.A.C.S.

In the spring of 1944 the 7th Field Hospital, Lt. Col. Berthel H. Henning commanding, was moved from North Ireland to the Eastern coast of England for maneuvers before the invasion. Our unit had had excellent training in the field in Texas and five months of hospital training in Ireland where we served as Station Hospitals (2) for the 2nd and 5th Divisions, as well as other smaller units. In England we ran across one problem in the field which we had not encountered before. This was methods of obtaining running water for scrubbing for surgery.

In scrubbing for surgery, one either had to use a basin or had to have someone pour water over his hands at desired intervals. Neither of these methods was desirable, especially if one was to do any amount of surgery. Besides this, water was in short supply in England and had to be conserved as much as possible.

I therefore designed an outfit by which running water could be obtained at any time and in which every ounce of water could be utilized to the best advantage. See diagram. This required a number 10 can with an outlet soldered in, rubber tubing which we obtained from plasma outfits and a few pieces of wood from boxes. It was built by T/3 Wyman W. Claggett from Hastings, Mich. and T/5 Albert A. Cerilli from Poughkeepsie, N.Y. These men subsequently built a portable sink to be used with it. They wound wire about the end of the rubber tubing, as shown in the diagram, to keep the end fixed. They also inserted the glass tip of an eye dropper, with the end cut off, in the end of the tubing to keep the stream constant.

PREVENTIVE MEDICINE

Two of these were used at one time with the portable sink and could be set up by merely inserting the rubber tube through the opening of the jaws and winding the wire about the end. Water of the desired temperature was placed in the containers and the personnel were then free for other duties. The ability to have warm water for scrubbing was very important on cold nights in France and Belgium since we were in tents almost without exception. Water was heated either on a stove or in the field sterilizers. When not in tents, at Metz and at Bastogne, there was no running water in the bombed out buildings and the outfit was just as valuable. The size of the stream was small but perfectly adequate. Indidentally this can be enlarged by using larger tubing and a larger container.

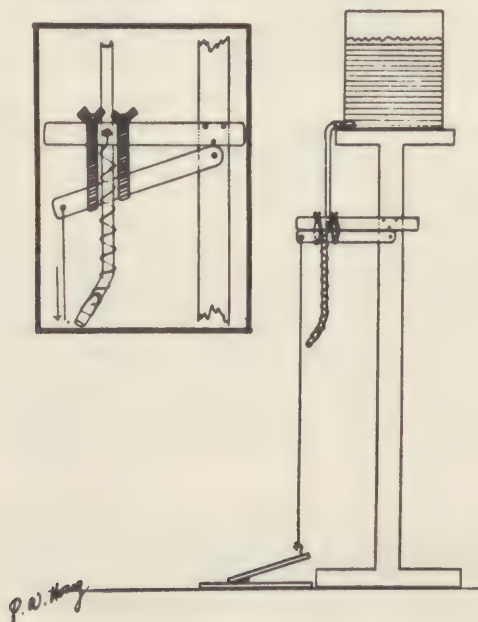
The main part of the outfit is the cut-off produced by the jaws. This can be attached as desired and the container with the water placed accordingly. It will be noted that two pieces of rubber tubing are placed so that the water tubing cannot move about in opening and closing the jaws. The diagram shows a single piece of tubing about the jaws on each side. For security and complete cessation of stream, we used the tubing wound twice. Many other modifications are self evident and will be used as desired.

This apparatus should be of value to all medical field outfits in first aid set ups as well as field hospitals.

We used this outfit not only in England but during the whole European Campaign, including August 1944 when we were stationed on an Air Strip in Nuremberg. In January 1945 the First unit was assigned to the 201st General Hospital for surgery until that outfit was completely equipped. It is of interest that when I showed this apparatus to Dr. Paul Adolph, their Chief of Surgery, he stated that he had used a very similar outfit in China, but that he had used a double boiler effect with water in each can in order to keep the water cool.

SUMMARY

A simple method for obtaining running water for use in cleansing hands or scrubbing in the operating room is presented which can be made very easily by any Medical Field Unit. It conserves water. It also enables the use of water at the desired temperature for scrubbing, a very important factor in cold climate.



(The above article is from "The Military Surgeon," May 1950, page 391)

PREVENTIVE MEDICINE

THE COMMON COLD AND ITS IMPLICATIONS Wm. J. Kerr, M.D., F.A.C.P., San Francisco, Calif. Annals of Internal Medicine - August 1950

(Extracts)

During the course of a year very few persons escape one or more attacks of the malady we may designate as the common cold.

There is very little factual information upon which all can agree. It is common knowledge that almost all persons living in a temperate climate will experience one or more attacks of upper respiratory disorders during the course of a year. A majority of these attacks occur during inclement weather and often appear in epidemic form during the fall months.

When attempts are made to define the common cold, difficulties begin, and multiply as we proceed. Is it infectious and, if so, what is the etiological agent? If there is little or no immunity conferred by an attack, why is this the case? What role does allergy play in the reactions in the nose and how could one differentiate hay fever from the common cold? What part does the physiological state of the nose and the body in general play in the production of symptoms and in what way does faulty reaction to cooling contribute to etiology? Can one "catch a cold" by sitting in a draught?

The common cold is an acute inflammation (not necessarily of infectious origin) of the upper respiratory tract, chiefly of the nasal mucous membrane, which manifests itself by local and by more or less disagreeable constitutional symptoms. Its etiology is as yet undetermined.

The structure and function of the nose are here of primary consideration. The nasal passages constitute the normal pathway for inspired and expired air; secondarily they contain the end organs of smell. In transmitting air, their chief function is to act as an air conditioner between the variable temperature and humidity of the atmosphere and the constant relatively high temperature and humidity of the delicate pulmonary structures. The mucous membranes covering the turbinate bones are highly developed erectile tissue, responding rapidly to needs in warming and humidifying the air.

The erectile tissue increases its turgescence upon demand for augmenting the dual functions of adding moisture and warming the inspired air. The common experience of rhinorrhea when first breathing very cold air attests to this function.

The physiological responses in the nose to external cooling have been studied over many years, and the results are not consistent. Contrary to the findings of Mudd and his co-workers, we found that chilling of the body surface causes nasal turgescence. By means of volume and temperature measurements in the nose, we found that general cutaneous chilling caused an initial drop in nasal temperature and increase in volume or breathing space, with then a gradual decrease in nasal volume while the nasal temperature was still falling. Thus turgescence impedes the passage of air. Upon warming the body after prolonged exposure to cold the nasal temperature rises and the nasal volume increases, indicating reduced volume of the turbinates. In our experiments, exposure such as a cold foot bath (13°C) on subjects in a warm room (29°C) caused at first a pronounced drop in nasal temperature, associated with a pronounced rise in nasal volume followed by a very rapid recovery to a point far beyond the initial levels while the stimulus was still being applied. The influence of draughts in warm subjects may thus be sufficient to cause nasal symptoms.

The general manifestations of the common cold are of considerable interest. The onset is ushered in with feelings of chilliness, at which time the skin is cold and pale. The oral temperature at this stage is generally normal or subnormal and remains so for hours or two to three days. At this stage the subject passes an increased amount of pale, low gravity urine. Later when the feelings of chilliness disappear, the skin presents a more normal color and the urine becomes scanty, is darker and of a higher specific gravity. In these respects the general reactions resemble those which are associated with protein shock and infectious diseases but which are not necessarily peculiar to infectious diseases.

The epidemiology of the common cold has been the subject of extensive study. One should not assume that a living agent must necessarily be responsible. The weather is subject to rapid

PREVENTIVE MEDICINE

fluctuations, and exposure to inclement weather conditions may also affect large numbers simultaneously. The heated air of relatively low humidity supplied to living areas in our homes and offices during cold weather makes excessive demands on our own air conditioning apparatus.

It is currently assumed by the profession that the etiological agent is a filterable virus or a family of them. While it is apparent that Dochez, Long, Topping, and Andrewes and their co-workers and others have isolated one or more viruses which will cause symptoms resembling those of the common cold in human subjects and apes, it is by no means proved that any one of these viruses is commonly present as an etiological agent. Studies on the epidemiology of the common cold leave us in a state of uncertainty. It is generally held that the common cold is highly contagious and elaborate rules of conduct are predicated on this belief. Personal experiences over many years convince me that the common cold, or what may be so designated, is not generally contagious.

The physiological mechanisms which are involved in the common cold and in diseases of known bacterial cause have not been adequately studied. The general manifestations in the neurovascular mechanisms are of great importance in relation to heat and water balance. Chills, sweating general aches and pains, headache, febrile responses and changes in concentration of the urine are manifestations of variations in these controlling bodily functions. The general symptoms of the common cold are in this broad frame of reference and do not necessarily imply that an infectious agent is responsible. An intravenous injection of bacterial vaccine or peptone will produce similar responses. The influence of fatigue, loss of fluids by sweating and dilatation of the peripheral vascular system from excessive and prolonged heat may predispose to defects in the mechanisms of control. This state is apparent in those who reside in the tropics and who are unable to adjust readily to the cooling atmosphere of the temperate regions when they are so exposed.

Would it not be reasonable to expect that, after a long period of hot summer weather when the heat regulatory mechanism is geared to greater heat loss, many people cannot adjust quickly to the cooling atmosphere which ushers in the early fall outbreaks of coryza which are the common cold?

What I have had to say may not have thrown much light into the nasal passages and the age-old malady which resides there. I do not believe, personally, that the common cold is contagious or readily spread by ordinary human contacts. I do not think that filterable viruses play much part in the spread of the disease. I think the physiological mechanisms permitting us to live in a temperate climate are in some way involved in causing symptoms and that our inability to respond to cooling is the major factor. The interrelation between the nasal mucosa and the peripheral neurovascular mechanisms is close and critical. Their altered responses may be the most significant etiological factor in setting off attacks even if infectious agents play some part in the disease. A closer coordination of effort between workers trained in virology, allergy, and physiology should aid in the solution of the problems.

* * *

SULFANILAMIDE

Sulfanilamide powder will not be applied to wounds except under the supervision of a qualified officer of the Medical Service. This powder is quickly washed out of a rapidly bleeding wound, and where there is but little bleeding it may form a crusty lump and so hinder healing.

The fact that some dressings, first aid (first aid packets), still contain sulfanilamide powder does not on that account render them unserviceable. Examining the container for breaks or tears is the only test to be employed to determine the serviceability of the dressings (first aid packets).

If the dressing, first aid (first aid packet), when opened for use, is found to contain sulfanilamide, the powder may be discarded. Containers of dressings, first aid (first aid packets), which still contain sulfanilamide will not be opened merely for the purpose of removing the powder. Such practice is undesirable as these containers are sealed under sterile conditions.

(The above article is from D/A Circular 55, 1950)

PREVENTIVE MEDICINE

RESTRICTED

GENERAL COMMENT

The health of the command continued to be excellent.

Unless otherwise indicated, reference to disease and injuries in this publication applies to all Class I and Class II installations exclusive of Walter Reed Army Hospital. Rates are calculated on the basis of a thousand mean strength per year. Statistics presently reported by Army medical installations do include those Air Force personnel who are treated or hospitalized at the reporting unit on a casual basis, since reciprocal use of other service's medical installation is made. (See General Data and Admissions Tables on page 16).

The non-effective rate* increased from the August rate of 11.64 to 13.04 for the month of September. Days lost as a result of disease and injury totaled 8,116 during the five week period ending 29 September 1950.

*Non-Effective Rate -- $\frac{\text{Total Days lost} \times 1,000}{\text{No. of days Average Daily in Period} \times \text{Strength}}$

Non-effective rates indicate the average number of patients in hospital or quarters per thousand mean strength during the report period.

The total admission rate** for disease and injury in September was 369.5, compared to 317.8 during August. Total admission for disease and injury in September was 630. Of this number, 566 admissions were for disease and 64 injuries. Fort Myer reported the highest admission rate, and All Others reported the lowest rate during the current month.

**Admission Rates -- $\frac{1,000 \times 365 \times \text{Number of Cases}}{\text{Mean Strength} \times \text{No. of Days in Period}}$

Admission rates show the number of cases per thousand strength that would occur during a year if cases occurred throughout the year at the same rate as in the report period.

September's rate for disease cases is 332.0 for 566 cases. Fort Myer reported the highest admission rate, and US Army Dispensary, The Pentagon, reported the lowest rate for disease cases.

An injury admission rate of 37.5 per 1,000 per annum for September was reported. This was a decrease from the August rate of 44.4. Fort McNair reported the highest rate and All Others reported the lowest rate for injuries.

There were no deaths reported during the five week period ending 29 September 1950, by units within the Military District of Washington less Walter Reed Army Hospital.

COMMUNICABLE DISEASE

Common respiratory diseases decreased in incidence during the month of September, 1950. The rate for the present month is 90.3 compared to the August rate of 92.4. Fort Myer reported the highest rate, and All Others, reported the lowest rate. Admission rates for pneumonia (all types) increased during the September report period. The rate being 1.2 compared with the August rate of .8. There were no cases of scarlet fever reported throughout the month of September.

No appreciable change was noted in the rate for mumps, tuberculosis, rheumatic fever, diarrheal disease, and hepatitis during the five week period ending 29 September 1950.

Pertinent statistical tables may be found on pages 17 and 24.

RESTRICTED

PREVENTIVE MEDICINE

RESTRICTED

GENERAL DATA
5-Week Period Ending 29 September 1950
(Data from WD AGO Forms 8-122)

STATION	MEAN STRENGTH			DIRECT ADMISSIONS						Non-Effective Rate	Number of Deaths
	Total	White	Negro	All Causes		Disease		Injuries			
				Cases	Rates	Cases	Rates	Cases	Rates		
Fort Belvoir, Virginia	8478	7164	1314	279	341.9	241	296.4	37	45.5	12.13	0
Fort McNair, Wash., D.C.	876	808	68	30	357.1	24	285.7	6	71.4	8.71	0
Fort Myer, Virginia	1391	1214	177	127	952.1	119	892.1	8	60.0	10.82	0
So. Post, Fort Myer, Va.	1663	1661	2	101	633.3	95	595.7	6	37.6	17.23	0
US Army Dispensary, Pentagon	3594	3573	21	60	174.1	55	159.6	5	14.5	19.10	0
All Others	1778	1778	0	34	119.4	32	187.7	2	11.7	5.08	0
Total Mil Dist of Wash.	17779	16196	1583	630	369.5	566	332.0	64	37.5	13.04	0
AMC - Med Det (Duty Pers)*	1633	1491	142	41	261.8	39	248.7	2	13.1	4.10	1
AMC - Med Hold Det*	1654	1553	101	163	1027.7	147	926.1	16	101.6	970.20	3
AMC - Total	2689	2477	212	153	593.3	139	539.0	14	57.8	481.20	2
TOTAL - Dept/Army Units	20468	18673	1795	783	398.9	705	359.2	78	39.7	74.06	2

*Army & Air Force Personnel Included

ADMISSIONS, SPECIFIED DISEASES - RATE PER 1000 PER YEAR
5 - Week Period Ending 29 September 1950
(Data from WD AGO Forms 8-122)

STATION	Common Respiratory Disease	Pneumonia All Types	Pneumonia Atypical	Influenza	Measles	Mumps	Scarlet Fever	Tuberculosis	Rheumatic Fever	Diarrheal Disease	Hepatitis	Malaria	Psychiatric Disease
Fort Belvoir, Virginia	82.6	1.2	1.2	-	-	1.2	-	3.7	2.5	-	1.2	-	8.6
Fort McNair, Wash., D.C.	23.8	-	-	-	-	-	-	-	-	11.9	-	-	-
Fort Myer, Virginia	322.4	-	-	97.4	-	-	-	-	-	-	-	-	-
So. Post, Fort Myer, Va.	150.5	-	-	-	-	-	-	-	-	-	6.3	-	-
US Army Dispensary, Pent.	49.3	2.9	2.9	2.9	-	2.9	-	-	-	-	-	-	-
All Others	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Military Dist of Wash.	90.3	1.2	1.2	8.2	-	1.2	-	1.7	1.2	.6	1.2	-	4.1
AMC - Med Det (Duty Pers)*	-	-	-	-	-	-	-	-	-	-	-	-	-
AMC - Med Hold Det*	6.3	6.3	-	-	-	-	-	6.3	-	6.3	-	-	-
AMC - Total	3.9	3.9	-	-	-	-	-	3.9	-	3.9	-	-	-

*Army & Air Force Personnel Included.

PREVENTIVE MEDICINE

RESTRICTED

VENEREAL DISEASE

Venereal Disease rate among units within the Military District of Washington, increased during the September report period.

The rate for September 1950 was 19.94, an increase over the August rate of 7.21. A total of 34 cases were reported for the five week period ending 29 September 1950. Of this total 32 were reported by Fort Belvoir, 1 for Fort Myer, and 1 for the US Army Dispensary, The Pentagon.

During the report period, white personnel incurred 18 of the reported number of cases, with a rate of 11.59 and 16 were incurred by negro personnel, with a resulting rate of 105.40 per 1000 troops per annum.

In order to enable non-professional personnel to more intelligently understand the rates of cases to personnel on duty at each designed station, we have undertaken to report the number of cases per 1000 men for this report period (September) in addition to the rate per 1000 per annum which is not always clearly understood and is often misinterpreted.

Pertinent statistical tables and charts may be found on pages 19, 20 and 21.

NEW VENEREAL DISEASE CASES - EXCL EPTS - JULY, AUGUST AND SEPTEMBER 1950

STATION	Rate per 1000 per year	Rate per 1000 per year	Rate per 1000 per year	Cases per 1000 Troops
	JULY 50	AUGUST 50	SEPTEMBER 50	SEPTEMBER 50
Fort Belvoir	32.09	14.55	39.36	3.774
Fort McNair	16.48	-	-	-
Fort Myer	-	9.74	7.50	.718
South Post, Fort Myer	-	-	-	-
US Army Dispensary, Pentagon	-	-	2.90	.278
All Others	30.96	-	-	-
Total Mil Dist Wash Units	19.36	7.51	19.94	1.912
Army Medical Center - Total	-	9.02	-	-
Total Dept/Army Units Mil Dist of Washington	16.74	7.77	17.32	1.661

RESTRICTED

RESTRICTED

PREVENTIVE MEDICINE

CHART 1

ADMISSION RATES BY MONTH, ALL CAUSES, COMMON RESPIRATORY DISEASE AND INJURY
MDW RATE PER 1000 TROOPS PER YEAR

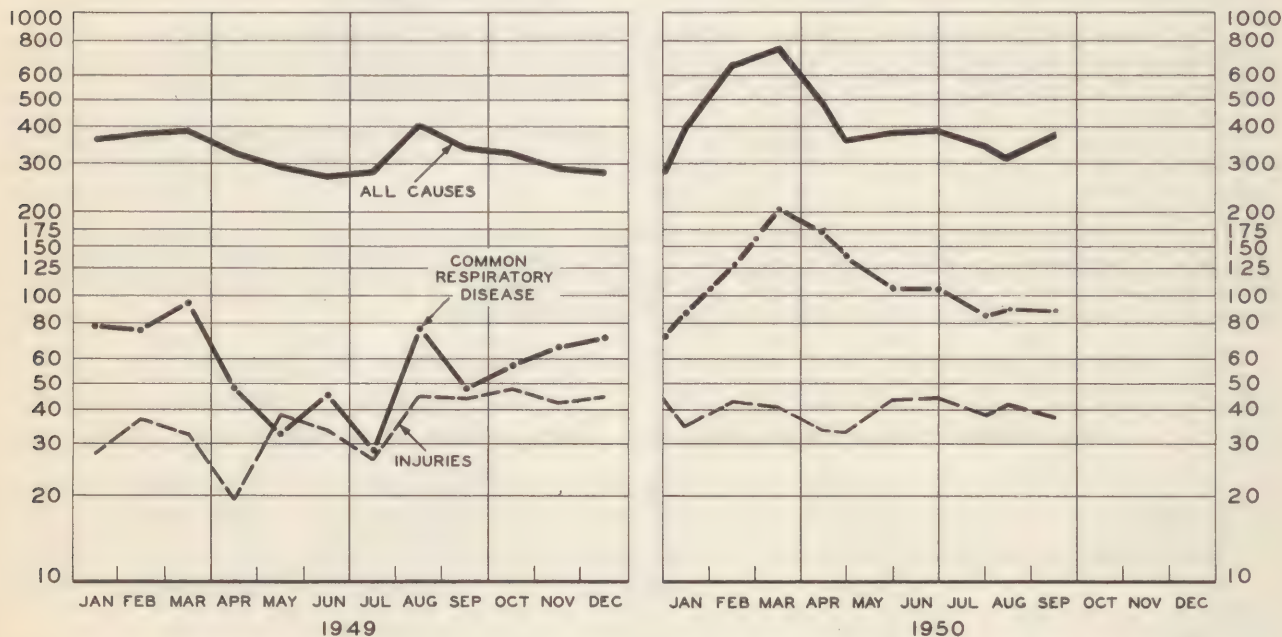
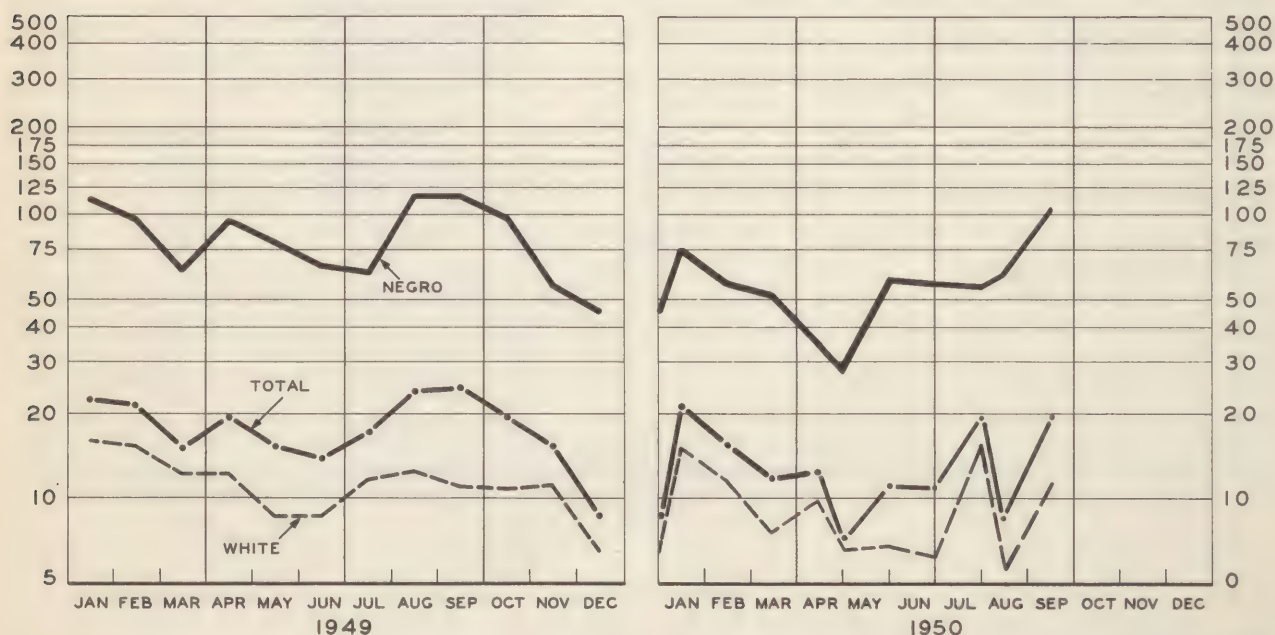


CHART 2

ADMISSION RATES BY MONTH VENEREAL DISEASES MDW INCL. ARMY MEDICAL CENTER
RATES PER 1000 TROOPS PER YEAR

INCLUDES ALL CASES REPORTED ON WD AGO 8-122 EXCEPTING THOSE EPTs

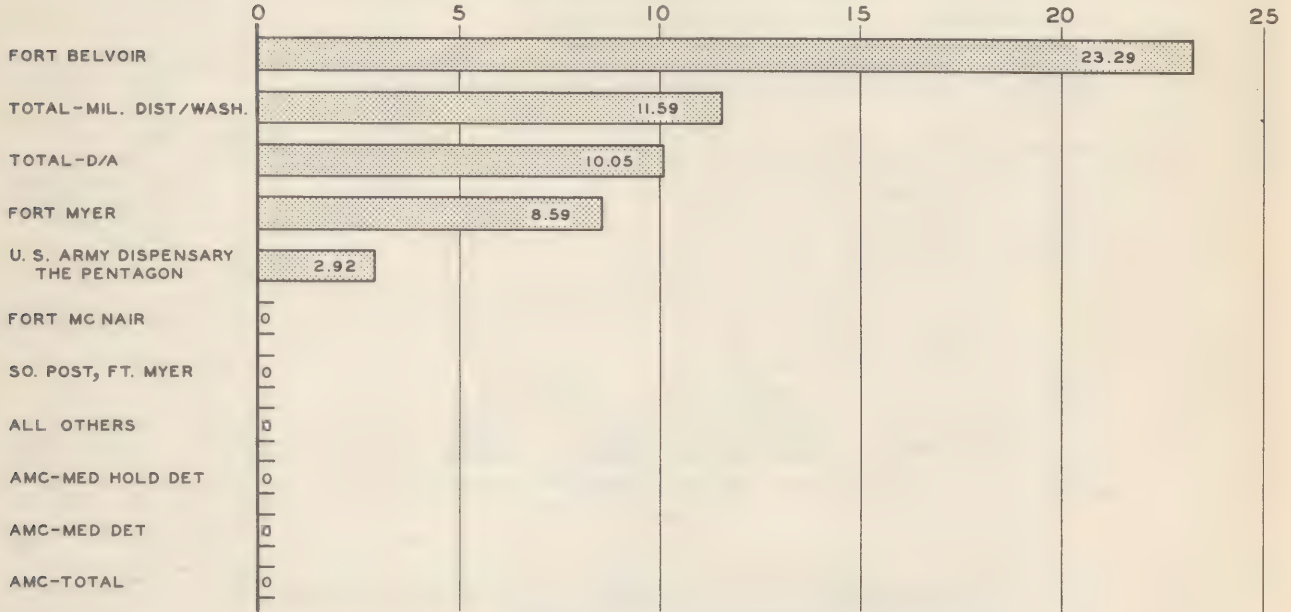


RESTRICTED

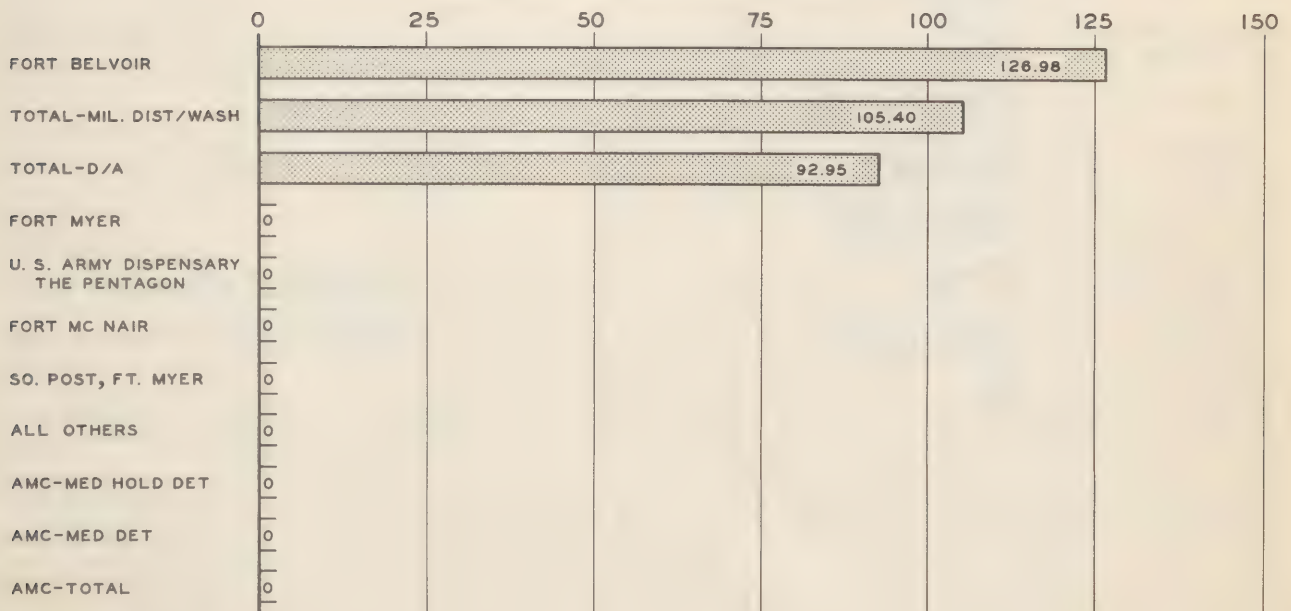
PREVENTIVE MEDICINE

RESTRICTED

VENEREAL DISEASE RATE PER 1000 TROOPS PER YEAR 5 WEEK PERIOD ENDING 29 SEP 1950 WHITE PERSONNEL (CHARGEABLE CASES)



VENEREAL DISEASE RATE PER 1000 TROOPS PER YEAR 5 WEEK PERIOD ENDING 29 SEP 1950 NEGRO PERSONNEL (CHARGEABLE CASES)



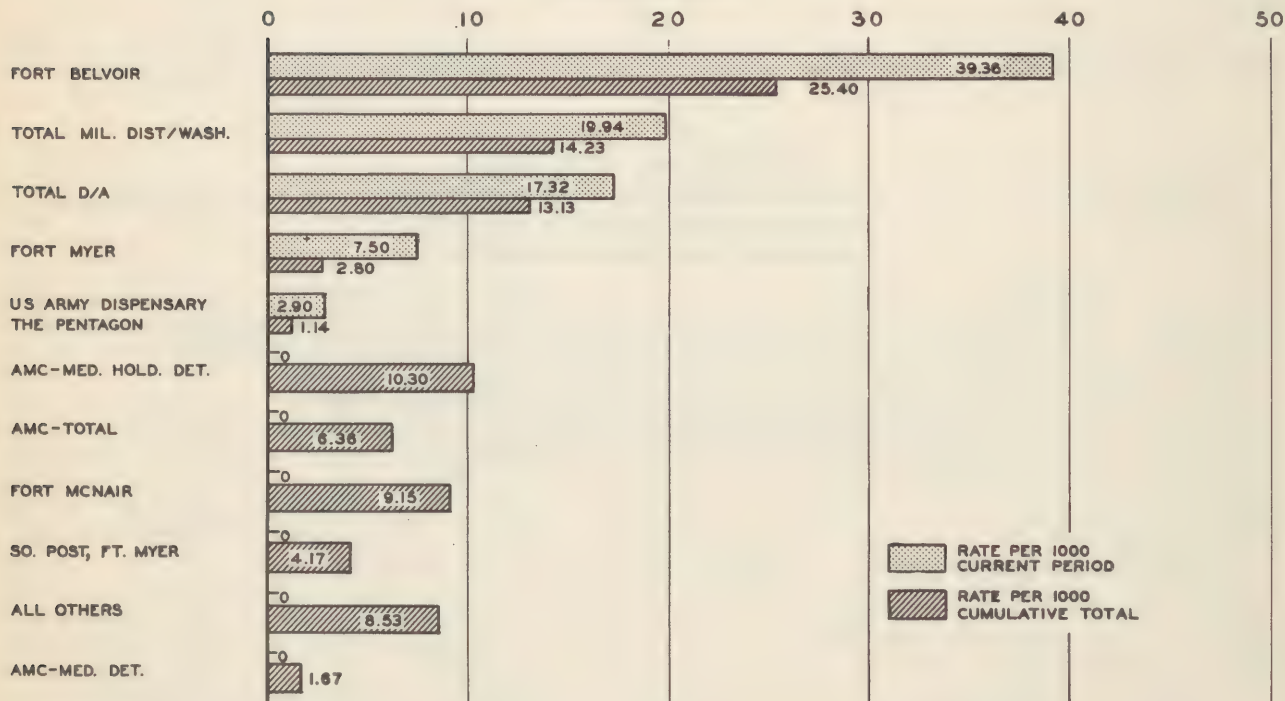
RESTRICTED

RESTRICTED**PREVENTIVE MEDICINE****VENEREAL DISEASE RATES FOR US***

(All Army Troops)

	JULY 1950	AUGUST 1950	SEPTEMBER 1950
First Army Area	16	16	21
Second Army Area	21	18	25
Mil District of Washington	16	8	17
Third Army Area	24	20	24
Fourth Army Area	14	24	18
Fifth Army Area	13	18	11
Sixth Army Area	17	26	34
TOTAL United States	18	20	22

**VENEREAL DISEASE
RATES PER 1000 PER YEAR
FIVE WEEK & CUMULATIVE TOTALS ENDING 29 SEP 1950
TOTAL WHITE & NEGRO PERSONNEL
(CHARGEABLE CASES)**

**RESTRICTED**

PREVENTIVE MEDICINE

RESTRICTED

CONSOLIDATED MONTHLY VENEREAL DISEASE STATISTICAL REPORT

For the Five Week Period Ending 29 September 1950

(Data from WD AGO 8-122) (Chargeable Cases)

STATION	R A C E	Mean Strength	Number of Cases-EPTS Not Included				Rate per 1000 Troops per Annum	Total Days Lost From Duty (Old & New Cases)
			Syphilis	Gonorrhea	Other	Total		
Fort Belvoir	W	7164	6	10	0	16	23.29	24
	N	1314	2	14	0	16	126.98	10
	T	8478	8	24	0	32	39.36	34
Fort McNair	W	808	0	0	0	0	-	0
	N	68	0	0	0	0	-	0
	T	876	0	0	0	0	-	0
Fort Myer	W	1214	0	1	0	1	8.59	0
	N	177	0	0	0	0	-	0
	T	1391	0	1	0	1	7.50	0
South Post, Fort Myer	W	1660	0	0	0	0	-	0
	N	2	0	0	0	0	-	0
	T	1662	0	0	0	0	-	0
US Army Dispensary, The Pentagon	W	3573	0	1	0	1	2.92	0
	N	21	0	0	0	0	-	0
	T	3594	0	1	0	1	2.90	0
All Others	W	1775	0	0	0	0	-	0
	N	0	0	0	0	0	-	0
	T	1775	0	0	0	0	-	0
Total Mil Dist of Wash	W	16196	6	12	0	18	11.59	24
	N	1583	2	14	0	16	105.40	10
	T	17779	8	26	0	34	19.94	34
Army Medical Center-Total	W	2477	0	0	0	0	-	0
	N	212	0	0	0	0	-	0
	T	2689	0	0	0	0	-	0
Total Dept/Army Units	W	18673	6	12	0	18	10.05	36
	N	1795	2	14	0	16	92.95	10
	T	20468	8	26	0	34	17.32	46

RESTRICTED

DENTAL SERVICE

RESTRICTED

DENTAL SERVICE - FIVE WEEK PERIOD ENDING 29 September 1950

STATION	Military		Civilian		Sit- tings	Amal- gam	Oxy and Amal	Sili- cate	In- lays	Bridges	Bridge Repair	Crowns	Dentures			Extrac- tions	Clacu- lus Removed	X-Rays	Exami- nations
	Men	Duty Days	Men	Duty Days									Full	Par- tial	Re- pair				
Fort Belvoir	10	253	1	20	2043	485	544	180	3	12	3	0	18	28	13	674	184	849	1035
Fort McNair	2	56	0	0	310	139	66	22	0	0	0	2	1	6	4	38	25	71	88
Fort Myer, Va.	2	56	0	0	793	292	26	67	1	0	1	1	1	13	10	49	26	707	183
So Post, Ft Myer	1	40	1	15	335	193	95	24	0	1	0	0	2	2	10	87	14	108	57
US Army, Dist.	6	178	0	0	2497	418	106	96	0	1	6	0	5	8	8	89	183	877	1735
All Others	1	30	0	0	180	64	22	23	0	0	0	0	0	2	0	32	57	34	70
Total - MDW	22	613	2	35	6158	1591	859	412	4	14	10	3	27	59	44	969	489	2646	3168

VETERINARY SERVICE

POUNDS MEAT AND MEAT FOOD AND DIARY PRODUCTS INSPECTED SEPTEMBER 1950
(Data obtained from WD AGO Forms 8-134)

STATION	CLASS * 3	CLASS * 4	CLASS * 5	CLASS * 6	CLASS * 7	CLASS * 8	CLASS * 9	TOTAL
Fort Lesley J. McNair		64,744	106,783		176,667		50,537	398,731
Fort Belvoir, Virginia		314,971	206,239		710,311	36,071	227,038	1,494,630
Alexandria Field Buying Office		411,333	96,294	517,316			65,686	1,090,629
Fort Myer, Virginia		154,670	161,379		342,376	5,366	128,299	792,090
Cameron Station, Virginia		185,024	100,064		278,583	5,840	81,148	650,659
Mil Dist/Washington Vet Det.	776,644							776,644
The Pentagon						254,812		254,812
TOTALS	776,644	1,130,742	670,759	517,316	1,507,937	302,089	552,708	5,458,195
REJECTIONS:								
Insanitary or Unsound								
Alex. Field Buying Office		206						206
Cameron Station, Virginia					348			348
Mil Dist/Wash Vet Det.	2,530							2,530
Not type, class or grade								
Alex. Field Buying Office		1,800						1,800
Mil Dist/Wash Vet Det.	33,500							33,500
TOTAL REJECTIONS	36,030	2,006			348			38,384

*Class 3 - Prior to Purchase
*Class 4 - On delivery at Purchase
*Class 5 - Army Receipt except Purchase
*Class 6 - Prior to Shipment

*Class 7 - At Issue
*Class 8 - Purchase by Post Exchange, Clubs,
Messes or Post Restaurants
*Class 9 - Storage

OUTPATIENT SERVICE

OUTPATIENT SERVICE

Consolidated statistical data on outpatient service, Military District of Washington, less Walter Reed Army Hospital, are indicated below for the five - week period ending 29 September 1950:

ARMY:

Number of Outpatients 4206
Number of Treatments 22488

NON-ARMY:

Number of Outpatients 7026
Number of Treatments 21515

NUMBER OF COMPLETE PHYSICAL EXAMINATIONS CONDUCTED 2592
NUMBER OF VACCINATIONS AND IMMUNIZATIONS ADMINISTERED 5804

HOSPITAL MESS ADMINISTRATION

HOSPITAL MESS ADMINISTRATION

STATION	JUNE 1950	JULY 1950	AUGUST 1950	SEPTEMBER 1950
Fort Belvoir				
Income per Ration	\$1.05	\$1.03	\$1.1074	\$1.1591
Expense per Ration	1.14	1.09	1.0177	.9019
Gain or Loss	-.09	-.06	+.0897	+.2572

RESTRICTED

DEPARTMENT OF DEFENSE

CIVILIAN EMPLOYEES HEALTH SERVICE PROGRAM

METROPOLITAN AREA OF WASHINGTON

DEPARTMENT OF DEFENSE BLOOD DONOR PROGRAM

In accordance with the provisions of memorandum from the Secretary of Defense dated 28 Sept 1950, subject, "Blood Donor Program, the Department of Defense Blood Donor Program" was activated as of 13 October 1950. The Director of Medical Services, Dr. Richard L. Meiling is named as the chairman of the Department of Defense Blood Donor Campaign. Dr. Meiling will act as liaison with the American National Red Cross.

A survey was conducted of available space for setting up the equipment necessary for the operation of the program and it was determined that the Civilian Employee Health Service Dispensary, Room 3A-750 was best suited because of its location and available space. This dispensary is reserved each Friday between the hours of 1000 and 1500 for volunteer blood donors.

All of us are aware of the scope and objectives of the Red Cross National Blood Program, however, it might be well to refresh our minds of this worthy service. The new Red Cross National Blood Program, however, it might be well to refresh our minds of this worthy service. The new Red Cross National Blood Program was officially started in January 1948 with the opening of the first regional blood center in Rochester, N.Y. This program was adapted to meet the peace time as well as possible emergency needs for whole blood or its fractions. More and more after World War II it became obvious that blood was a pillar of national health. More blood and blood fractions were needed to meet emergencies.

The World War II record of the American Red Cross Blood Donor Program is noteworthy. In February 1941, at Army and Navy request, the American Red Cross started a blood donor service. The blood was processed for its plasma for the U. S. Armed Forces. One figure really sums up the dramatic story - 13,326,242 pints of blood given freely by the American people before the program ended on September 15, 1945. At the peak of donations, Americans gave one pint of blood every two seconds. Donations then averaged 110,923 pints of blood per week.

Since the opening of the first regional blood center in Rochester, N.Y. in 1948 many new regional centers were opened and will continue to be opened until complete coverage for the United States is established. At the start of the program, it was estimated that at least 3,700,000 pints of blood would be needed each year to meet normal civilian needs. This meant one donation of blood a year by one out of every twenty five American adults. The total needed each year is increasing as new uses are found for blood and blood fractions.

The activities of the Red Cross Blood Program must materially increase and will be closely integrated with any plan of military and civil defense.

Blood cannot be made synthetically. The only source of supply is from human veins. Each Friday from 1000 to 1500 hours at the Department of Defense Blood Donor Center, Room 3A-750, The Pentagon, there is a staff available to accommodate a minimum of 100 donors. Tell your immediate supervisor or your recruitment chairman that you wish to be a volunteer blood donor or report on any Friday to Room 3A-750. Encourage your friends to also volunteer. Here are some lines in a "Thank you" leaflet that the Red Cross National Blood Program distributes:

"You can be proud all of your life of what you have done today. At least one other person will be grateful for it all of his life. For to him or her, this pint of blood that you have given can mean the difference between life and death".

CIVILIAN EMPLOYEES HEALTH SERVICE PROGRAM

DEPARTMENT OF DEFENSE METROPOLITAN AREA OF WASHINGTON CIVILIAN EMPLOYEE HEALTH SERVICE REPORT

The first three months operation of the Department of Defense, Civilian Employee Health Service Program, Metropolitan Area of Washington was completed 30 September 1950.

The following brief resume of the activities of the Civilian Employee Health Service Program for the period 1 July to 30 September 1950 inclusive is outlined for the information of all who are concerned or interested.

The program presently embodies two main dispensaries, seven branch dispensaries and six first aid rooms which are operated under the supervision of the main dispensaries. The present staff consists of four full time medical officers, seven part time medical officers, an administrative assistant, 33 nurses, 1 technician and 11 clerks.

Within the past quarter period 3,551 preplacement physical examinations, 66 periodic, re-check physical examinations, 597 other physical examinations including conversion, overseas assignment, transfer and terminal examinations, were performed. There were six cases of occupational illness reported and fifteen treatments administered for occupational illness. Occupational injuries reported were 1,519 and treatments for occupational injuries totaled 2,350. A total number of 35,069 non-occupational illnesses and injuries requiring 40,606 emergency on the job treatments were reported. There were 2,089 medical consultations conducted by staff medical officers and 1,536 referrals for definitive treatment to private physicians of civilian employees.

Number of chest x-rays were 6,828. This included the following: 3,551 for preplacement physical examinations, 66 for periodic recheck physical examinations, 2,900 chest x-rays for the chest x-ray survey for tuberculosis, 111 radiographs as a part of the diagnosis of chest injury or disease. The remainder were for other types of physical examinations as required, i.e., overseas assignments, fitness for continuance of duty, transfer, etc.

Treatments administered to civilian employees of the Department of Defense for their convenience by written authority from their private physician totaled 5,651.

Since the inception of this program, 1 July 1950, the professional staff has been augmented by three part time medical officers and two full time nurses. Existant vacancies are being filled as qualified personnel can be recruited.

A full time Medical Officer and an additional full time nurse have been assigned for duty at the Civilian Employee Health Service Dispensary, Main Navy Building. A part time medical officer has been assigned for duty at Arlington Navy Annex and Tempo B Building, Civilian Employee Health Service Dispensaries. Two part time medical officers and one full time nurse have been assigned to fill existant vacancies at the Civilian Employee Health Service Dispensary, Pentagon.

Staff members of the Army Industrial Hygiene Laboratory have conducted surveys at two Civilian Employee Health Service Dispensaries and requests are approved for additional surveys. Recommendations of the Army Industrial Hygiene Laboratory for the elimination or control of occupational hazards found during the surveys are being carried out.

Additional medical equipment and supplies are in the process of procurement. When available the additional equipment and supplies will implement medical service and treatment for the civilian employee.

Additional space was available at the Bureau of Yards and Docks for the expansion of the dispensary. Alterations have been completed there and soon additional equipment will be added. Professional services of a medical officer will be available at this dispensary. The first aid room at Potomac Annex has been completely remodeled and redecorated. Plans are being studied for additional space at other dispensaries of the Civilian Employee Health Service Program.